California Health Policy and Data Advisory Commission
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Minutes
California Health Policy and Data Advisory Commission
August 31, 2006

The meeting was called to order by Chairperson Vito Genna at 10:00 a.m., at the Sterling Hotel, 1300 H Street, Sacramento, California. A quorum (defined as 50 percent plus one) was in attendance.

Present:

William Brien, MD
Vito J. Genna, Chairperson
Janet Greenfield, RN
Howard L. Harris, PhD
Jerry Royer, MD, MBA
Corinne Sanchez, Esq.
Josh Valdez, DBA
William Weil, MD

Absent:

Marjorie Fine, MD
Sol Lizerbram, DO
Kenneth M. Tiratira, MPA

CHPDAC Staff: Kathleen Maestas, Acting Executive Director; Janna Brady, Retired Annuitant

OSHPD Staff: David M. Carlisle, MD, PhD, Director; Dale Flournoy, Deputy Director, Cal-Mortgage Loan Insurance Division; George Fribance, Cal-Mortgage Loan Insurance Division; Michael Rodrian, Deputy Director, Healthcare Information Division; Joseph Parker, PhD, Manager, Health Quality and Analysis; Jonathan Teague, Healthcare Information Resources Center; Elizabeth Wied, Chief Counsel; Beth Herse, Staff Counsel; Starla Ledbetter, Patient Discharge Data

Others in Attendance:

Dorel Harms, California Hospital Association; Darryl Nixon, California Association of Health Facilities; and Robert Powell, California Health Information Association

Oath of Office:

Dr. Carlisle administered the oath of office to Josh Valdez, recently appointed to the Commission by the Governor. Dr. Valdez has been in healthcare for twenty years, starting when he was in the Air Force. He currently is Senior Vice President for Wellpoint, responsible for all healthcare in three states: California, Nevada and Colorado.

Chairman Genna gave a brief summarization of CHPDAC's committees and encouraged all Commissioners to attend meetings.

Approval of Minutes:

The minutes from the meeting of June 2, 2006 were approved.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, OSHPD

There have been some leadership changes at OSHPD. Kurt Shaefer, Deputy Director, Health Facilities Division, has announced his retirement effective September 30. John Gillengarten will be Acting Deputy Director until a permanent CEA examination is conducted and an appointment is made. Brenda Russell is filling in as Interim Manager of the Health Professions Education Foundation.

OSHPD recently received an award from the State Controller's Office for the accounting section. This is the third or fourth award received during the past few years from Controller's Office for OSHPD's financial reports.

OSHPD is in the process of discussions with the Department of General Services and Department of Finance to negotiate space for the K Street office and to relocate other parts of the Office.

Acting Executive Director's Report: Kathleen Maestas

The October 16 meeting will be held in Monterey. The December 8 CHPDAC meeting will be held in San Francisco. The annual holiday dinner will be held on Thursday, December 7.

Dr. Weil requested that the Commission roster be expanded to include CHPDAC staff and phone numbers.

AB 524 Technical Advisory Committee (TAC) Report: Jerry Royer, MD, MBA, Chairman

The two main topics discussed at the last TAC meeting were community-acquired pneumonia and maternal outcomes. The pneumonia report was distributed to hospitals on June 15 for a 60-day review. One conclusion which triggered much discussion was the finding of 12 percent mortality in pneumonia. A comment was made that maybe OSHPD should abandon the other reports and focus on pneumonia. This is not possible because of statutory mandates. Pneumonia affects greater populations than any other study done by OSHPD. What are the processes the better hospitals are doing that the poorer hospitals are not doing? California Hospital Association (CHA) and California Medical Association (CMA) should be working on best practice and how to improve the rates.

Dorel Harms of CHA said SB 739 (Speier) is moving through the houses and is expected to pass which will require hospitals to do certain things about hospital-acquired pneumonia. There is also a group of chief medical officers looking at the variation analysis that Jack Wennberg conducted.

Commissioner Valdez said he is working on a pay for improvement plan for 2007, where hospitals would compete against themselves.

The other key topic was discussion of do not resuscitate (DNR) orders. Using DNR in the model, the analysis showed that a third of the outlier hospitals moved back into the middle, or expected range.

There was discussion about doing corrective action, such as quality improvement and performance improvement, not within the mandate of TAC. There are deaths that probably need not occur if OSHPD were to capture the differences in processes among the outliers. There was discussion on how to report this. There needs to be more discussion on using DNR.

The contractor for the maternal outcomes report fell behind schedule and there has been difficulty in bringing this to closure. The contractor gave an excellent report on readmission rates, perineal lacerations, third and fourth degree lacerations, vaginal birth after a cesarean section (VBAC) and C-sections. There has been concern about the high C-section rate, which is higher than in European countries. The high rate may stem from fear of ruptured uterus in VBACs and an increased demand on the part of both patients to determine when to have delivery. There is believed to be an increased use of C-section by physicians for convenience. Family physicians do not deliver babies any more in California because of the high premiums for malpractice insurance, and only OB-GYNs do C-sections.

A question that needs to be answered: Is the C-section causing a problem of more complications or has the healthcare improved through the high C-section rate?

Cal-Mortgage Report: Dale Flournoy, Deputy Director, Cal-Mortgage Loan Guarantee Program

The Commission receives a report from the Cal-Mortgage Loan Guarantee Program biennially. The mission of the program is to stimulate the flow of capital and to provide the program, without cost, to the State of California as a self-supporting program. The program provides a guarantee of repayment. The lender or borrower transfers the risk to the State of California by overlaying its credit insurance on top of the credit rating of a borrower, resulting in a lower interest rate for the borrower.

The program is authorized to underwrite up to three billion dollars, with an underlying capital base or insurance fund of more than $170 million trust fund backing. Only non-profit, city and county health facilities (hospitals, continuing care, primary care clinics, alcohol/drug and substance abuse, group homes, etc.) may apply for a loan.

Healthcare Information Division Update: Michael Rodrian, Deputy Director

Dr. Andy Bindman has completed the report on expanding patient level data for quality assessment. Dr. Carlisle has requested CHPDAC's committee to review the report and give feedback on utility, feasibility, and, if adopted, implementation timing of new data elements. This report is in response to legislation which authorized adding up to 15 data elements in

any five-year period to the patient discharge database. Items that will be added because of national data standards are in addition to the 15 data elements. Copies of the report have been distributed to CHPDAC, HDPIC and TAC members. OSHPD is currently analyzing the report as well.

The Department of Health Services will be reorganized into two separate departments through legislation currently going through the Legislature. Each of the two departments will depend on data which OSHPD collects. OSHPD data is linked to Medi-Cal data to look at healthcare trends, hospital costs. OSHPD data is also merged with birth and death statistics, important for analyses of trends and healthcare and quality. There is also specialized information on avoidable hospitalizations, preventable hospitalizations, asthma, diabetes, as well as information on emergency room and ambulatory surgery used in emergency preparedness and injury prevention programs.

Mr. Rodrian distributed a handout on the Regional Health Information Organizations, which is a collaborative effort to incrementally build the structure and capabilities necessary for a secure statewide health information exchange system that enables California's healthcare providers and patients to access vital medical information at the time and place needed.

The first focus is to establish a relationship between physicians, and then between physicians and patients which includes an electronic medical record that can be accessed.

The second focus is to reach out more to statewide databases that already exist and allow better sharing of information, also to look at trends, healthcare analyses, and measuring healthcare quality. As more information becomes electronically available, the cost of providing that information and turnaround time should be shortened.

CalRHIO is also trying to establish a vocabulary among all the different players about healthcare data and build on national standards and state standards in transmitting that data.

In the future, it is really looking at physician practice of medicine becoming electronic. A discussion at the last meeting was how to make this a financial good thing for physicians, patients and insurance companies, etc. Some participants thought if there is an accepted statewide electronic signature for physicians that would be an inducement for moving into an automated world in their practices; from writing prescriptions to sending medical records to other organizations.

OSHPD should be involved as these technologies emerge in order to be cognizant of what is going on.

Dorel Harms reported that a proposed legislative bill by Senator Alquist would have required electronic health records for California by the year 2014. A few weeks ago, the Governor came out with a directive about electronic health records for legislation next year, and the Alquist legislation was dropped.

The proposed regulations for MIRCal are going through the public comment period. The comment period closes on September 4. This brought some of the data elements in line with national standards.

Starla Ledbetter recently received a national award from the California Health Information Association for her work on national standards and for her work with hospitals.

Progress/Update on Healthcare Outcomes Center: Joseph Parker, PhD, Manager

The Maternal Outcomes program is back on track.

Staff is developing some national quality measures that have been produced by the Agency for Healthcare Research and Quality.

The patient discharge data collected by OSHPD is used widely by researchers nationally and internationally. This data is used by OSHPD to generate risk-adjusted outcome reports for hospitals, but had not been validated. OSHPD has entered into a contract with Dr. Andy Bindman at the University of California, San Francisco, to validate some of the data, focusing on newer data elements such as "condition present at admission" (CPAA) and "do not resuscitate" (DNR). CPAA is associated with patient diagnosis, and tells whether a condition occurred prior to admission or post-admission. The validation of DNR is necessary to assess whether hospitals capture DNR information within 24 hours of hospitalization.

The draft community-required pneumonia report used data from 2002-2004 and was sent to hospitals for a 60-day review period. We were informed that some hospitals were coding source of admission from board and care homes instead of coming from their own residence. Persons coming from an institutional setting can be exposed to antibiotic-resistant pathogens.

There was some discussion about the outcome reports going to the Health Data and Public Information Committee prior to publication. The Chair of that Committee, Dr. Harris, said the Committee should talk about the press release process and dissemination. It was suggested that a summary be sent to Committee members.

The pneumonia report will also be released with updated data next year, which will give three years of data. OSHPD has entered into a contract to update the risk factors used in the model.

There is need for further discussion about including DNR as a risk factor for pneumonia and heart attack reports. DNR predicts risk, but there is potential for influencing the care that a patient receives.

There was interest in explaining to the public that the large variation in rates is not really acceptable and that it is a QI issue. Probably what will be done in this report is to emphasize the need for hospitals and society to take on QI efforts to bring down the gap between the best-performing and the worst-performing hospitals.

The maternal outcomes report occupied the most time at the TAC meeting. The TAC wanted to see five different elements in the report, two of which are risk-adjusted third and fourth degree perineal laceration rates, along with risk-adjusted readmission rates and hospital performance ratings. They would also like to see risk-adjusted VBAC rates and some indication of high or low status and a C-section rate for women who have had prior births and indication. They wanted to show these indicators in a more consumer friendly approach. The HDPIC would have a role in this.

The TAC was interested in some healthy baby measures and that just providing maternal outcome measures was not seen as sufficient. However, the contract for the report only includes maternal outcomes. It was recommended that if valid measures of neonatal mortality are available and easily incorporated into the report, they should be looked at.

There were even larger differences in hospital rates for lacerations and readmissions than found in pneumonia. There was some concern that some of the high outliers for readmission rates were UC hospitals.

There were 303 hospitals involved in the study. More than one third of the hospitals were in the better or worse categories. There was some discussion about different thresholds of statistical significance. Race and ethnicity was a predictor of perineal lacerations as were baby size, breech, level of maternal education, length of time between deliveries. There was some debate about whether to release the report using 2000-2001 data or whether to wait and combine it with 2003-2005 data in the spring of 2007.

The Commission members were interested in receiving a copy of the presentation given at the TAC meeting.

Dr. Harris said this is powerful information but could be grossly misunderstood. Dr. Parker said there are some resources on the web to help journalists understand risk-adjusted outcomes and he had some references. In writing the press release, staff tries to anticipate some of the questions. Some of the information is in the talking points, which are not widely disseminated. It was suggested that Dr. Harris attend the next TAC meeting. The maternal outcomes report is a more consumer oriented report.

Apart from educating or changing behavior of physicians and hospitals, are consumers being educated and changing their behavior? Most of the mothers are more worried about the baby being healthy than themselves.

After some discussion about what to do with the data, it was said that OSHPD should spread the data to those who are empowered to act with the data. More meaningful data is coming out earlier at the same time that State and Federal Governments are calling for an emphasis on reporting of quality information. It is thought there will be more focus and attention given to the reports.

The California CABG Outcomes Reporting Program is a mandated program. The first mandatory report was at the hospital level. Staff is working on a report that includes outcomes for both physicians and hospitals. There are 120 hospitals in California that performed heart bypass surgery. There are 303 surgeons whose outcomes are reported in

the current report, using 2003 and 2004 data. All surgeon risk-adjusted mortality rates and their associated volumes will be reported, even if surgeons have low volume. In this report, for the first time, there will be reporting on process of care measures. Many of these measures have been implemented and are the basis for some pay distribution, reimbursement.

The preliminary reports were mailed to hospitals and surgeons in July for a 60-day review period.

Adjournment: The meeting adjourned at 2:31 p.m.